**Deanship of Graduate Studies**

**Al-Quds University**


# The Use of Rehabilitation Outcome Measures in Palestine:

# A Descriptive Study

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**M.Sc. Thesis**

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# A Descriptive Study

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# Thesis Approval

# The Use of Rehabilitation Outcome Measures in Palestine: A Descriptive Study

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# Dedication

I dedicate my success in presenting this study to the one who taught me giving without expecting anything in return, to the one whose name I carry with pride, to the spirit of my dear father.

To whom do you give me love and determination, my dear mother?

I dedicate it to my star sisters who shine in the sky of my presence.

To all family, friends and colleagues.

# Declaration

This thesis is submitted in partial fulfillment of the requirement for the Master's degree in physical therapy.

I declare that the content of this thesis (or any part of the same) has not been submitted for a higher degree to any other University or institution.

Raia Mahmoud Hadban Morjan

Signed:

RAIA MAHMOUD

Date: 16/7/2023

# Acknowledgment

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# The Use of Rehabilitation Outcome Measures in Palestine; A Descriptive Study

**Prepared by:** Raia Mahmoud Hadban Morjan

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## Abstract:

**Background:**

Standardized Outcome Measures (SOMs) have been differently defined in literature, including the use of a tool to assess the patient's current situation, as well as the assessment of the impact of specific interventions. The use of SOMs is valid worldwide, as it is associated with several positive consequences on the health and quality of care.

**Objectives:** This study aimed to to investigate the use, benefits and problems related to the implication of SOMs among Palestinian physiotherapists.

**Methods:** The current study adopted a cross-sectional descriptive design and recruited a convenient sample of 30 physiotherapists from different cities in West Bank – Palestine, who received a self-administered valid questionnaire to assess the perceived benefits and problems related to the use of SOMs. Data were analyzed using SPSS software, with the commitment to the ethical principles of anonymity and confidentiality.

**Results**: The sample contained 63.3% females, with 36.7% of 11-20 years of experience, and 83.3% of baccalaureate professional degree, mainly working in outpatient facilities (83.3%) and treating all ages of patients (86.7%). More than three fourths of the participants (76.7%) stated that they use SOMs with their patients. The proportional scores showed an overall positive attitude toward the benefits (91.11 ± 8.85), problems (65.71 ± 10.45) and use (80.77 ± 10.30) of SOM< as well as the overall score (77.61 ± 6.77). None of the demographic factors were considered significant predictor for the use of SOM (p-value > 0.05).

**Conclusion**: The use of SOMs is important in the field of physiotherapy, yet it is underestimated in the Palestinian settings, as it is scarce in the literature. There is a need to focus on such topics, with more studies, larger sample sizes and more rigorous.

**Keywords:** Standardized Outcome Measures, Physiotherapy, benefits and problems.

# استخدام مقاييس مخرجات التأهيل في فلسطين: دراسة وصفية

**الإعداد: ريا محمود هدبان مرجان**

**اشراف: د. عبد الحميد الزير**

## ملخص عن الدراسة باللغة العربية

**المقدمة:** يتم تعريف مقاييس مخرجات التأهيل (SOM) بشكل مختلف في الأدبيات، بما في ذلك استخدام أداة لتقييم الوضع الحالي للمريض، وكذلك تقييم تأثير التدخلات المحددة. يعد استخدام SOM صالحًا في جميع أنحاء العالم، حيث يرتبط بالعديد من النتائج الإيجابية على الصحة وجودة الرعاية.

**الهدف :** هدفت الدراسة الحالية الى التحقق من الاستخدام والفوائد والمشاكل المتعلقة بتطبيق SOM بين أخصائيي العلاج الطبيعي في فلسطين.

**المنهج المتبع للدراسة:** اعتمدت الدراسة الحالية تصميمًا وصفيًا مقطعيًا وجندت عينة ملائمة من 30 معالجًا فيزيائيًا من مدن مختلفة في الضفة الغربية - فلسطين، والذين تلقوا استبيانًا صالحًا من الإدارة الذاتية لتقييم الفوائد والمشكلات المتعلقة باستخدام مقاييس مخرجات العلاج والتأهيل. تم تحليل البيانات باستخدام برنامج SPSS، مع الالتزام بالمبادئ الأخلاقية المتمثلة في إخفاء الهوية والسرية.

**نتائج الدراسة:** اشتملت العينة على 30 مشاركا/ة منهم 63.3٪ إناث، مع 36.7٪ / 11-20 سنة خبرة في مجال التخصص، و83.3٪ من جملة شهادة البكالوريا المهنية، يعمل افراد العينة بشكل أساسي في العيادات الخارجية (83.3٪) ومعالجة المرضى من جميع الأعمار (86.7٪). ذكر أكثر من ثلاثة أرباع المشاركين (76.7٪) أنهم يستخدمون مقاييس مخرجات التأهيل مع مرضاهم. أظهرت التوزيعات النسبية والمتوسطات الحسابية والدرجات النسبية موقفًا إيجابيًا إجماليًا تجاه الفوائد (91.11 ± 8.85)، والمشكلات (65.71 ± 10.45) واستخدام مقاييس مخرجات العلاج والتأهيل (80.77 ± 10.30) بالإضافة إلى النتيجة الإجمالية (77.61 ± 6.77). لم يتم اعتبار أي من العوامل الديموغرافية مؤشرا هاما للتنبؤ باستخدام مقاييس مخرجات العلاج والتأهيل في فلسطين (قيمة $p> 0.05$).

**الاستنتاجات**: إن استخدام مقاييس مخرجات العلاج والتأهيل مهم في مجال العلاج الطبيعي، ومع ذلك يتم التقليل من شأنه في الأوساط الفلسطينية. هناك حاجة إلى التركيز على مثل هذه الموضوعات، مع تنفيذ المزيد من الدراسات التي تحتوي على أحجام أكبر من العينات والمناطق.

الكلمات المفتاحية: مقاييس مخرجات العلاج والتأهيل، العلاج الطبيعي، الفوائد والمشاكل.

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# List of abbreviations

SOMs: standardize outcome measurements.

SRM: self-reported measures.

PBM: performance-based measures.

ORM: observe-reported measures.

CRM: clinician-reported measures.

D: disagree.

SA: somewhat agree.

DA: defiantly agree.

# Chapter One

## 1.1 Introduction

## 1.2 Problem statement

## 1.3 Study justification “Rational”

## 1.4 Study Hypothesis

## 1.5 Study Objectives

## 1.6 Terminology & Abbreviation

# Chapter One: Introduction

## 1.1 Background

Outcome assessment involves developing outcome measurement. Outcome measures are defined as a tool used to assess a patient current situation (Melchert, 2011). Also defined as measures chosen to assess the impact of the intervention sit may provide a score which is an explanation of the result and sometimes it's considered a dangerous classification for the patient(Outcome measures and case definition," 2015).

In 1996, KEN HOWORD, said in a book of foundations of professional psychology "it is not sufficient for the practitioner to know that a particular treatment can work (efficacy) or does work (effectiveness) on average ... The practitioner needs to know what treatment is likely to work for a particular individual, and then whether the selected treatment is working for this patient"(Melchert, 2011).

In clinical practice for health care professionals, outcome measures are divided into four categories: first measures that required either therapist to interview the patient or patient can independently complete it by himself, had a paper "fixed" or "computerized" form / *self-reported measure (SRM)*(Weldring et al., 2013). Second, we had measures that require the patient to perform a set of movements or tasks, scoring can be based on either an objective measurement or qualitative assessments / *performance-reported measures (PRMs)*. *Observer-reported measures (ORMs)*(*Types of Patient-Reported Outcomes - Patient-Reported Outcomes in Performance Measurement - NCBI Bookshelf*, n.d.)are the third type completed by the person who regularly observes the patient. Finally, *clinician-reported measures (CRMs)* which done by the clinician using clinical judgments and reports about the patient's behaviour(Powers et al., 2017).

There are two types of self-reported measures, the first of which includes measures that are reported directly by the patient without an explanation of his response by the doctor or therapist. Another concept includes the instruments and equipment used to measure patient-reported metrics and by which a wide range of health-related concepts are measured.

Examples of these measures include health-related quality of life, functional status, symptoms and symptom burden, health behaviors, and patient health care experience (Hefford C , 2011 ). It should also be noted that recent studies are increasingly turning to studying the health care experience as a quality indicator of patient care and safety.

When looking at the performance-reported outcome measures, we find a wide range of assessment tools that simulate various health areas such as neurology and orthopedics, including age groups ranging from children to the elderly. For example, the ASIA Scale, a standard neurological assessment scale routinely applied in foreign countries, is also one of the international standards for the neurological classification of SCI (Mulroy SJ,2011). Another example of performance-based scales is the 6 minutes' walk test, a patient walks for 6 minutes under the instruction of a healthcare professional, and the distance the patient walked is measured as a performance outcome (Jette DU, 2009).

The Pediatric Quality of Life Inventory is an example of an observer-reported outcome measure and it is a good example cause children being the most visible group in terms of their need for care as they go through their developmental stages, as it includes different units of pediatric health conditions. The function of this tool lies in evaluating the risks and tracking the health status of the child as well as evaluating the effect of the therapeutic intervention on him. This scale can also be used to evaluate children with good health, such as school students.

For the Clinician-reported measures, there are three main classifications, including: Readings and ratings global ratings (Richardson D, 2002) . Where these assessments are created through the procedures of some form of information. An example is the performance case of the Eastern Collaborative Oncology Group (ECOG), which oncologists use to describe a patient's performance in terms of their ability to care for themselves, daily activity, and physical ability.

One of the important things that must be taken into account when using outcome measurements is psychometric properties. Psychometric properties include validity, inter-rater reliability, intra-rater reliability, responsiveness, ceiling effects, floor activity, and P-value.

At present, outcome measures have become universally recognized, and their use in the field of education and clinical training of health professions is a means for accurate diagnosis of the patient and based on it the selection of the optimal rehabilitation program to provide high-quality health care and also to monitor changes in the patient's condition. Outcome measures also contribute to documenting information, provide a credible and reliable justification for treatment on an individual patient level and thus, building a database with the moving toward evidence-based practice in health care.

## 1-2 Problem statement

The complexities found in outcomes improvements are particularly challenging worldwide. Achieving a better level in the health care system It's a golden goal, starting with our education at university up to working in the field. When I was a university student, there was no specialized course in outcome measures, and this made it difficult for me when dealing with patients in terms of accuracy in assessment, understanding the situation, taking appropriate measures and building a treatment plan based on a scientific basis. It was also noticed by browsing the research conducted in this field that there are no case studies of outcome measures in Palestine, whether in terms of the importance of use or their inclusion in the health system. With regard to the health system in the local reality, the Ministry of Health has not imposed any laws that require physical therapists to use outcome measures in hospitals and rehabilitation centers, which creates a gap, knowing that the inclusion of their use leads to a better health level leading to a better evidence-based practice.

# 1-3 Study justification

The logical analysis of the importance of our existing study, in that it sheds light on important points about the state of outcome measures in the Palestinian health community, are as follows:

1. Training students in practice on the use of outcome measures so that they have the opportunity to enter into the logic of outcome measures in training centers.
2. This study gives in its fruits an opportunity for rehabilitation institutions to judge the state of improvement of patients by comparing the results of evaluations upon entry and

after completion of receiving rehabilitation services, and in this style, we reach governance in collecting information and using outcome measures.

3. Another importance of this study is that it provides an opportunity for comparison between rehabilitation institutions, as the use of outcome measures as an indicator and guide to the level of improvement shows us which of these institutions has the best evaluation, and this means the best rehabilitation services provided to patients.

## 1.4 Research Objectives

1. To describe the extent to which physical therapists know the importance of using assessments that are known and proven to be used globally.
2. To explore the difficulties encountered during the use of SOM in rehabilitation
3. To determine the differences in benefits, problems and use of SOM according to the demographic and professional factors of the participants.

## 1.5 Research Questions

1. What are the most important barrier that stand in the way of the use and practical application of outcome measures in Palestine?

2. Are the barrier due to the scientific knowledge “whether theoretical or practical “of the therapists”, or due to the gap in the health system?

3. What are the current systems followed by the Ministry of Health in this field and what are the requirements to adopt and improve the use of SOM to a better level?

## 1.6 Research hypothesis

The use of physiotherapy’s standardized outcome measures in Palestine has a positive impact on the quality of services in the national health care system. And helps in building a comprehensive and professional database of rehabilitation in Palestine.

## 1.7 Terminology

- **Standardize outcome measures**: An outcome measure is a device, tool, or procedure that collects data on the desired outcome. A set of closely related outcome measures that offer information on the same underlying skill or ability is referred to as an outcome domain.

- **Rehabilitation Outcome Measures** is a detailed examination and comparison of rehabilitation measuring tools. It covers an overview of professional practice in physiotherapy as well as an introduction to the World Health Organization's (WHO) International Classification of Health.

- **Self-reported measures**: Any approach that involves asking a participant about their feelings, attitudes, views, questionnaires and interviews are examples of self-reports; self-reports are frequently used to get participant answers in observational studies and experiments.

- **Performance-based measures:** Performance-based measurements require that the patient execute a series of motions or activities. Scores for performance-based measurements might be based on an objective measurement (e.g., time to finish a task) or a qualitative assessment with a score.

- Measurements done by a parent, caregiver, or someone who consistently watches the patient on a daily basis are known as observer-reported measures.

- Clinician-reported measures are those that are filled out by a health care provider. The professional employs clinical judgment and reports on patient behaviors or indications that are noticed.

# Chapter Two
# Literature Review

## 2.1 Theoretical Studies

## 2.2 Similar Studies

# Chapter Two
# Literature Review
## 2.1 Theoretical studies:

Recently, outcome measures have become a familiar scientific term for audiology and are being used among colleagues in the field, and are taught to university students in health professions specializations "physiotherapy and rehabilitation". The importance of this study lies because it seeks to take a closer look to describe the scientific and practical knowledge culture as well as the evaluations used “practice and the mechanism of choice” according to the selection evidence and psychometric characteristics in proportion to the pathological condition after conducting diagnoses and clinical examinations. On the other hand, describing the academic preparation of students and exploring the obstacles and requirements to be used as a data documentation tool. This research is also presented under the recommendations mentioned in the scientific research on outcome measures, which recommend conducting further studies. By conducting this descriptive research to explore the status of outcome measures, we aim to build an informatics institution to use outcome measures as a tool for collecting information in the middle of physical rehabilitation in Palestine.

Using an Evidence-Based Approach to Measure Outcomes in Clinical Practice MacDermid, Grewal et al had published a handbook in February 2009, at which it was cited by 19 researchers, and the topic of the research revolves around the research's focus is on the fact that there are increasingly more patients in rehabilitation facilities, while physical therapists are occasionally unsure of the precise interventions.
We arrive at the conclusion that a systematic approach to outcome measurements is required to evaluate the impact of evidence-based practice and comprehend the implications for clinical decisions given patient expectations and the present state of the evidence.

Given patient expectations and the current state of evidence, we conclude that a systematic approach to outcome measures is necessary to assess the impact of evidence-based practice and understand the implications for clinical decisions(MacDermid, Grewal et al. 2009).

Another study entitled Monitoring the change: Current trends in outcome measure usage in physiotherapy “that was published in the manual therapy book in February 2006, and it was cited by 84 researchers, Physiotherapists have traditionally relied on impairment measures such as range of motion and muscle strength to monitor patient progress. The impact of treatment on patients' daily activities can be assessed with valid and reliable questionnaires, but the use of standardized questionnaires by physiotherapists appeared to be limited. This study found a significant increase in the use of some standardized outcome measures by physiotherapists over 6 months. The changes observed were likely influenced by active education initiatives, professional support, and peak body position statements(Abrams et al., 2006).

A patient's firsthand account of a health outcome is known as a patient-reported outcome (PRO). It contrasts with an outcome that was reported by someone else, such as a doctor's report, a nurse's report, etc. In clinical trials and other therapeutic settings, PRO techniques like surveys are employed to better understand a treatment's efficacy. In today's health research environment, the usage of digital PROs, also known as electronic patient-reported outcomes (ePROs), is growing.

Patient-centered outcomes, often known as PCOs, should not be confused with PROs. The latter suggests the use of a questionnaire that addresses difficulties and worries unique to a patient. Patient-reported outcomes, on the other hand, refer to reporting circumstances in which only the patient gives information on a particular therapy or condition; this information may or may not be of concern to the patient.
Furthermore, PREMs (patient-reported experience measures), which place more emphasis on a patient's entire experience than on particular treatment results, should not be mistaken with PROs. The terms "patient-reported outcome measures" (PROMs) and "PROs" are frequently used interchangeably.

In cases where it covers many qualities, a well-designed PRO questionnaire should consist of a number of scales, each of which assesses a different attribute. These "characteristics" of the measurement are referred to as constructs, and the surveys used to gather them are referred to as instruments, measures, scales, or tools. PRO tools often need to go through rigorous validation and testing.

One-dimensionality is the measurement of a single construct through a questionnaire. A unidimensional questionnaire's items (questions) can be combined to get a single scale score. A questionnaire's one-dimensionality cannot, however, be inferred from the fact that the creator intended it to be so. It is necessary to provide empirical evidence for this (by using confirmatory factor analysis or Rasch analysis, for instance). Multi-dimensional refers to a questionnaire that assesses numerous constructs. To offer a profile of scores, a multi-dimensional questionnaire is employed; specifically, each scale is scored and presented independently. Using factor analysis or preference-based methodologies, it is feasible to produce an overall (single summary) score from a multi-dimensional measure; however, some people could compare this to combining apples and oranges.

When adopting an outcome measure, its psychometric properties are crucial characteristics that must be considered. An outcome measure's inherent qualities are its psychometric features. An outcome measure used in practice should, ideally, have undergone a number of research studies to establish and test its psychometric features. Validity, intra-rater reliability, inter-rater reliability, responsiveness, ceiling effects, floor effects, and minimal clinically significant differences are some of these features. The test's validity is determined by how closely it measures the intended outcomes. A measure with high validity may be relied upon to accurately measure the intended focus.

When two different people are evaluating the outcomes of the same subject, inter-rater reliability takes the consistency of the measure's results into account. With performance-based measurements, strong inter-rater reliability would indicate that both physiotherapists who rated the performance came to identical conclusions about the performance under consideration.

A high intra-rater reliability for patient-reported outcome measures denotes that the patient consistently reacts to get the same findings. This is especially true for serial testing without any intervention or status change.Test-retest reliability includes intra-rater reliability. The term "responsiveness" describes a measure's capacity to recognize changes in status. When the majority of patients successfully complete the measurement and score in the top range of the measurement, this phenomenon is known as the "ceiling effect." The test is too simple and does not adequately assess their abilities. When the vast majority of patients fall within the lowest range of the measurement, this is known as a "floor effect."

(The test is too difficult, and there aren't enough simpler items to discriminate between different status levels.) The p-value has little significance for deciding whether a change is relevant. The clinician needs to be aware of the least important difference for outcome measurements. The phrase "minimal important difference" describes how little of a change the patient may notice as being important.

## 2.2 Similar Studies

The following similar studies in table 2.1 were found and used in this study.

**Table 2.1 Similar studies in the field of SOMs in Rehabilitation**

| Study | Author | Published Year |
|---|---|---|
| **Implementation and use of standardized outcome measures by physical therapists in Saudi Arabia: barriers, facilitators and perceptions(Al-Muqiren, Al-Eisa et al. 2017)** | "Tahani N. Al-Muqiren, Einas S. Al-Eisa, Ahmad H. Alghadir& Shahnawaz Anwer BMC Health Services Research" | 21 November 2017 |
| **Clinical and biomechanical outcomes of rehabilitation targeting intersegmental control in athletic groin pain: prospective cohort of 205 patients(King, Franklyn-Miller et al. 2018)** | "Enda King , Andrew Franklyn-Miller, Chris Richter , Eamon O'Reilly , Mark Doolan , Kieran Moran, Siobhan Strike , Éanna Falvey " | 2018 |
| **Mastering Prognostic Tools: An Opportunity to Enhance Personalized Care and to Optimize Clinical Outcomes in Physical Therapy(Tousignant-Laflamme, Houle et al. 2022)** | 'Yannick Tousignant-Laflamme, PT, PhD, Catherine Houle, MPT, Chad Cook, PT, PhD, MBA, FAPTA, Florian Naye, PT, MSc, Annie LeBlanc, PhD, Simon Décary, PT, PhDv' | 2022 |
| **Use of Physical Activity Measures in Rehabilitation Interventions Following Lower Extremity Amputation(Murray and McGinty 2023)** | Murray, L<br>Mcginty, · G | 2023 |

| | | |
|---|---|---|
| **Outcome measures in physiotherapy management of patients with stroke: a survey into self-reported use, and barriers to and facilitators for use(Van Peppen, Maissan et al. 2008)** | Roland P S Van Peppen , Francois J F Maissan, Frank R Van Genderen, Rob Van Dolder, Nico L U Van Meeteren | 2008 |
| **Physiotherapists' behaviour, attitudes, awareness, knowledge and barriers in relation to evidence-based practice implementation in Saudi Arabia: a cross-sectional study(Alshehri, Alalawi et al. 2017)** | Mansour A Alshehri , Ahmed Alalawi, Hammad Alhasan, Emma Stokes | 2017 |
| **Current use and barriers and facilitators for implementation of standardised measures in physical therapy in the Netherlands(Swinkels, Van Peppen et al. 2011)** | Raymond A H M Swinkels , Roland P S van Peppen, Harriet Wittink, Jan W H Custers, Anna J H M Beurskens | 2011 |
| **Facilitators and barriers to using neurological outcome measures in developed and developing countries(Demers, Blanchette et al. 2019)** | Marika Demers, Andréanne K Blanchette , Aditi A Mullick , Akash Shah, Kathleen Woo, John Solomon, Mindy F Levin | 2019 |

## 2.3 Summary

The most frequently cited reasons for not using such measures were the time needed for patients to complete them, the time needed for doctors to interpret the data, and the difficulty for patients to complete them independently.

The majority of evaluations of prognostic tools in the rehabilitation literature have concentrated on prescriptive clinical prediction principles. These investigations reveal significant methodological difficulties and reach the conclusion that these instruments are neither reliable not effective in clinical practice. This has highlighted the necessity to broaden the area of study in order to understand what constitutes a high-quality prognostic tool that can be utilized in clinical practice.

# Chapter Three

## Methods

**3.1 Study method & design**

**3.2 Study sample**

**3.3 Eligibility criteria**

**3.4 Tools of data collection**

**3.5 Study variables**

**3.6 Ethical approval**

**3.7 Statistical analysis**

# Chapter Three

## 3-1 Study design

The present study used a descriptive study design to assess the use of standardized outcome measurement status in Palestinian rehabilitation centers and privet clinics.

A cross sectional web survey-based was used in previous similar study, The questionnaire was translated into Arabic by a legal translator licensed by the Ministry of Justice, to preserve the credibility and effectiveness of the basic questionnaire. The aim of translation was to facilitate understanding and mobilization by therapists.

## 3-2 Study setting

The questionnaire was distributed among the therapists in the form of a link via social media. After two weeks, a reminder was sent to fill out and confirm participation. Due to the short period of time, the responses were closed and 30 responses were taken, which is consistent with the statistical analysis.

## 3-3 Study Sample

### 3-3-3-1 Study Procedures

On January 23, 2023, the electronic link "Google Forms" for the survey started to circulate on the Facebook pages of the Palestinian physical therapists in Palestine. It was also disseminated via the WhatsApp messaging service. The response rate was 10 therapists after a week. Physical therapists were contacted by phone and email to remind them that the tasks needed to be finished.

Then, the researcher managed to get in touch with 19 physical therapists. Unfortunately, when the researcher reached out to some well-known rehabilitation facilities in West Bank, the administration did not reply, which had an adverse effect on the sample's size and thoroughness.

After roughly a month and a few days, the link was posted once more through social media for Physiotherapy groups as well as on WhatsApp application with the assistance of colleagues who follow it.

By talking and following up with the supervisor, there was no responses, and the necessary statistical analyses carried out on 30 subjects to finish the study. The study includes some of the physiotherapist who are working in the national rehabilitation centers and private clinics that offer physical therapy and rehabilitation services.

### 3-3-2 Sampling method

The sample included all governorates of West Bank in Palestine, in terms of geographical distribution, where the largest percentages of subscribers were represented in Hebron governorate by 30% and Ramallah and Al-Bireh governorates by 16.7%, while the lowest percentages were represented in the governorates of Tulkarem and Jericho by 3.3%.

Years of experience between 11-20 years accounted for 36.7%, while the percentage of educational attainment was that the majority of therapists hold a bachelor's degree.

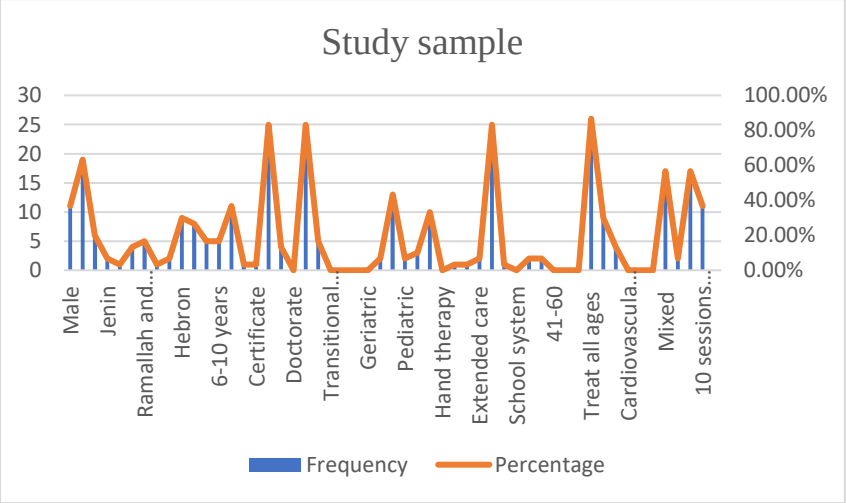


Figure 3.1 Demographic data of study sample

### 3-3-3 Sample size

The research sample consisted of 30 physical therapists (19 females - 11 males) who hold a valid professional practice and work in the practical field, whether in their own private centers or in other centers. The selection of physical therapists was based on their voluntary response to the online questionnaire, and according to the place of work and place of residence of the participants.

### 3-3-4 Inclusion criteria

Physical therapists with master's, bachelor's, or diploma degrees, and heads of departments in private rehabilitation clinics.

### 3-3-5 Exclusion criteria

Occupational and physical therapy students who only have training courses, and who are working in Centers offering relaxing massage services.

## 3-4 Data collection

### 3-4-1 Tools of data collection

1. The original version of the data collection tool was used in the study Monitoring the change: current trends in outcome measure usage in physiotherapy(Abrams et al., 2006), the same tool was used in the study conducted in Saudi Arabia in 2017. The researcher translated the original English version, to Arabic to facilitate common understanding and filling by the participants, and the translation was validated to ensure the credibility of the original version of the questionnaire.
2. Google Forms was used using the localized version in order to distribute the questionnaire and obtain the data.
3. In the final stage, the data were returned to the English language to be compatible with the study and to be subject to statistical analysis.
4. Look “Appendix I” for the content of the used questionnaire
5. That questionnaire included applied information concerning the knowledge and use of rehabilitation outcome measure.

## 3.5 Study variables

1. Physiotherapist information: gender, region, Years of practice, Professional (entry-level) degree, Highest earned degree, Specialty certification, Type of work facility, Age of patients, Type of conditions, Number of sessions in an 8-hour day. Table 3.1
2. The applied system for the use of outcome measures in the Palestinian center of rehabilitation: "Policies or procedures used in your practice setting for collecting information from SOM" Table 3.2
3. Benefits of using SOMs: Helping to direct the plan of care, Enhancing communication between therapist and patient/client, Enhancing communication with third-party payers, physicians, and other providers, Helping patients/clients feel that therapists are thorough in their examination, Increasing the efficiency of examinations, Helping to focus choice of interventions, Attaining better patient/client outcomes, Helping to motivate and encourage patients/clients, Decreasing the rates of denial from third-party payers, Enhanced marketing of my practice or services.
4. Barriers in front of using SOMs from the questionnaire: Are confusing to patients/clients, Are difficult for patients/clients to complete independently, Require too high a reading level for many patients/clients, Are in English, a language in which many of my patients/clients are not fluent, Are not sensitive to the cultural/ethnic concerns of many patients/clients, Make patients/clients anxious, Take too much time for patients/clients to complete, Take too much of clinicians' time to analyze/calculate/score, Provide information that is too subjective to be useful, Require more effort than they are worth, Do not contain information that helps to direct the plan of care, Are difficult to interpret (eg, do not know what norms are, how score relates to severity, or what a clinically important change might be), Do not contain the types of items or questions that are relevant for the types of patients/clients I see, Often do not get completed at discharge, so are not useful for determining patients'/clients' response to treatment, Require training that I do not have, Cost too much, Require a support structure that I do not have (eg, technology, staffing), Are really only useful for research purposes, Are not relevant because my practice involves consultation, case management, or discharge planning only.

## 3-5 Statistical analysis

Data were analyzed by using the statistical package for Social Sciences (SPSS) version 23. Descriptive and inferential analysis were performed. The scale variables were expressed as mean ± SD, while categorical variables were expressed as frequency.

The applied statistical tests of non-parametric descriptive statistics "frequencies and ratios", and inferential statistics "chi square and binary logistic regression" were used to describe the data of the study variables and to test the hypothesis of the study. SPSS software was used to run the statistical analysis.

## 3-6 Ethical considerations

The research proposal was submitted to the ethical committee of Al-Quds University and obtained the pre required ethical approval to apply it. "see appendix III for the letter of ethical approval".

# Chapter Four

# Results Presentation, Analysis & Discussion

## 4.1 Results presentation and analysis

### 4.1.1. Statistical results of sample Demographic data

### 4.1.2. Statistical results of benefits for using SOM with patients

### 4.1.3. Statistical results of Problems in using SOM with patients

### 4.1.4. Statistical results of questions related to the use of SOM with the patients

### 4.1.5. The statistical results of answers related to Policies and procedures used in practice setting for collecting information from SOM

### 4.1.6. Results related to reasons of not using the SOMs

### 4.1.7. Prediction of using SOMs by demographic factors of the study sample

### 4.1.8. Relationship between the main dimensions of study questionnaire

## 4.2 Results discussion

# Chapter Four

## 4-1 Results presentation and analysis

### 4.1.1. Statistical results of sample Demographic data

**Table (4.1) Frequency, ratio, and chi square results of sample Demographic data**

| Variables | Values | F | % | Chi square | df | Sig |
|---|---|---|---|---|---|---|
| Gender | Male | 11 | 36.7% | 2.133[a] | 1 | 0.14 |
| | Female | 19 | 63.3% | | | |
| Region | Jerusalem | 6 | 20.0% | 14.800[b] | 7 | 0.03 |
| | Jenin | 2 | 6.7% | | | |
| | Tulkarem | 1 | 3.3% | | | |
| | Nablus | 4 | 13.3% | | | |
| | Ramallah and Al-Bireh | 5 | 16.7% | | | |
| | Jericho | 1 | 3.3% | | | |
| | Bethlehem | 2 | 6.7% | | | |
| | Hebron | 9 | 30.0% | | | |
| Years of practice | <3 years | 8 | 26.7% | 9.333[c] | 4 | .05 |
| | 3-5 years | 5 | 16.7% | | | |
| | 6-10 years | 5 | 16.7% | | | |
| | 11-20 years | 11 | 36.7% | | | |
| | >20 years | 1 | 3.3% | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| Professional (entry-level) degree | Certificate | 1 | 3.3% | 34.200[d] | 2 | <.01 |
| | Baccalaureate | 25 | 83.3% | | | |
| | Master's | 4 | 13.3% | | | |
| | Doctorate | 0 | 0.0% | | | |
| Highest earned degree | Professional | 25 | 83.3% | 13.333[a] | 1 | <.01 |
| | Advancedmaster's | 5 | 16.7% | | | |
| | TransitionalDPT | 0 | 0.0% | | | |
| | Doctorate | 0 | 0.0% | | | |
| Specialty certification | Cardiovascular-pulmonary | 0 | 0.0% | 17.667[c] | 4 | <.01 |
| | Geriatric | 0 | 0.0% | 75.333[c] | | |
| | Neurology | 2 | 6.7% | | | |
| | Orthopedic | 13 | 43.3% | | | |
| | Pediatric | 2 | 6.7% | | | |
| | Sports | 3 | 10.0% | | | |
| | Manual therapy | 10 | 33.3% | | | |
| | Handtherapy | 0 | 0.0% | | | |
| Type of work facility | Acutecare | 1 | 3.3% | 38.400[d] | 4 | <.01 |
| | Inpatientrehabilitation | 1 | 3.3% | | | |
| | Extended care | 2 | 6.7% | | | |
| | Outpatient | 25 | 83.3% | | | |
| | Homehealth | 1 | 3.3% | | | |
| | Schoolsystem | 0 | 0.0% | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| Age of patients you manage | <21 | 2 | 6.7% | 38.400[d] | 2 | <.01 |
| | 21-40 | 2 | 6.7% | | | |
| | 41-60 | 0 | 0.0% | | | |
| | 61-75 | 0 | 0.0% | | | |
| | >75 | 0 | 0.0% | | | |
| | Treat all ages | 26 | 86.7% | | | |
| Type of conditions you manage | Musculoskeletal | 9 | 30.0% | 8.600[d] | 2 | <.01 |
| | Neuromuscular | 4 | 13.3% | | | |
| | Cardiovascular-pulmonary | 0 | 0.0% | | | |
| | Woman's health | 0 | 0.0% | | | |
| | Integumentary | 0 | 0.0% | | | |
| | Mixed | 17 | 56.7% | | | |
| Number of sessions in an 8-hour day | <5 sessions | 2 | 6.7% | | | |
| | 5-9 sessions | 17 | 56.7% | | | |
| | 10 sessions and more | 11 | 36.7% | | | |
| Use of SOM with patients | Yes | 23 | 76.7% | 26.600[a] | 2 | <.01 |
| | No | 1 | 3.3% | | | |
| | Maybe | 6 | 20.0% | | | |

The gray highlighted sig values indicate significant difference between the categories of the matched variable

### 4.1.2. Statistical results related to benefits of using SOMs for patients

**Table (4.2) Frequency, ratio, & chi square of questions related to benefits of using SOMs for patients**

| Statement | D | | SA | | DA | | Mean* | Chi square sig |
|---|---|---|---|---|---|---|---|---|
| | F | % | F | % | F | % | | |
| 1. Helping to direct the plan of care. | 0 | 0.0% | 5 | 16.7% | 25 | 83.3% | 2.83 | <.01 |
| 2. Enhancing communication between therapist and patient/client | 0 | 0.0% | 6 | 20.0% | 24 | 80.0% | 2.80 | <.01 |
| 3. Enhancing communication with third-party payers, physicians, and other providers | 0 | 0.0% | 13 | 43.3% | 17 | 56.7% | 2.57 | .46 |
| 4. Helping patients/clients feel that therapists are thorough in their examination | 0 | 0.0% | 5 | 16.7% | 25 | 83.3% | 2.83 | <.01 |
| 5. Increasing the efficiency of examinations | 0 | 0.0% | 6 | 20.0% | 24 | 80.0% | 2.80 | <.01 |
| 6. Helping to focus choice of interventions | 0 | 0.0% | 7 | 23.3% | 23 | 76.7% | 2.77 | <.01 |
| 7. Attaining better patient/client outcomes | 0 | 0.0% | 6 | 20.0% | 24 | 80.0% | 2.80 | <.01 |
| 8. Helping to motivate and encourage patients/clients | 0 | 0.0% | 5 | 16.7% | 25 | 83.3% | 2.83 | <.01 |
| 9. Decreasing the rates of denial from third-party payers | 2 | 6.7% | 15 | 50.0% | 13 | 43.3% | 2.37 | <.01 |
| 10. Enhanced marketing of my practice or services | 0 | 0.0% | 8 | 26.7% | 22 | 73.3% | 2.73 | **.01** |
| **Mean score ± SD** | **Total** | 27.33± 2.66 | | **Mean*** | 2.733 ± 0.266 | **Prop.*** | 91.11% ± 8.86% | |

The gray highlighted sig values indicate significant difference between the categories of the matched variable

* The mean and the proportional scores ensure positive attitude of the sample subjects concerning the benefits of using SOMs for patients

### 4.1.3. Statistical results of Problems in using SOM with patients

**Table (4.3) Frequency, ratio, and chi square results of questions related to Problems in using SOM with patients.**

| Statement | D | | SA | | DA | Mean* | | Chi square sig |
|---|---|---|---|---|---|---|---|---|
| | F | % | F | % | F | % | | |
| 1. Are confusing to patients/clients | 6 | 20.0% | 22 | 73.3% | 2 | 6.7% | 1.87 | <.01 |
| 2. Are difficult for patients/clients to complete independently | 1 | 3.3% | 23 | 76.7% | 6 | 20.0% | 2.17 | <.01 |
| 3. Require too high a reading level for many patients/clients | 1 | 3.3% | 22 | 73.3% | 7 | 23.3% | 2.20 | <.01 |
| 4. Are in English, a language in which many of my patients/clients are not fluent | 1 | 3.3% | 13 | 43.3% | 16 | 53.3% | 2.50 | <.01 |
| 5. Are not sensitive to the cultural/ethnic concerns of many patients/clients | 11 | 36.7% | 14 | 46.7% | 5 | 16.7% | 1.80 | .12 |
| 6. Make patients/clients anxious | 12 | 40.0% | 15 | 50.0% | 3 | 10.0% | 1.70 | .02 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 7. Take too much time for patients/clients to complete | 4 | 13.3% | 12 | 40.0% | 14 | 46.7% | 2.33 | .06 |
| 8. Take too much of clinicians' time to analyze/calculate/score | 3 | 10.0% | 16 | 53.3% | 11 | 36.7% | 2.27 | .01 |
| 9. Provide information that is too subjective to be useful | 8 | 26.7% | 19 | 63.3% | 3 | 10.0% | 1.83 | <.01 |
| 10. Require more effort than they are worth | 10 | 33.3% | 17 | 56.7% | 3 | 10.0% | 1.77 | <.01 |
| 11. Do not contain information that helps to direct the plan of care | 16 | 53.3% | 11 | 36.7% | 3 | 10.0% | 1.57 | .01 |
| 12. Are difficult to interpret (eg, do not know what norms are, how score relates to severity, or what a clinically important change might be) | 10 | 33.3% | 14 | 46.7% | 6 | 20.0% | 1.87 | .20 |
| 13. Do not contain the types of items or questions that are relevant for the type of patients/clients I see | 11 | 36.7% | 16 | 53.3% | 3 | 10.0% | 1.73 | .01 |
| 14. Often do not get completed at discharge, so cannot give information about patients'/clients' response to treatment | 5 | 16.7% | 20 | 66.7% | 5 | 16.7% | 2.00 | <.01 |
| **Mean score ± SD** | **Total** | 27.6 ± 4.39 | **Mean** | 1.97 ± 0.314 | | **Prop.** | 65.71% ± 10.46% | |

The gray highlighted sig values indicate significant difference between the categories of the matched variable

* key of mean score “range of disagree, range of somewhat agree, range of definitely agree” Neutral attitude in the above answers of the study sample concerning the problems in using SOMs

### 4.1.4. Statistical results related to the use of SOM with the patients

**Table (4.4) Frequency, ratio, and chi square results of questions related to the use of SOM with the patients.**

| Statement | No | | Yes, sometimes | | Yes, routinely | | Mean* | Chi square sig |
|---|---|---|---|---|---|---|---|---|
| | F | % | F | % | F | % | | |
| 1. Answering clinical questions through a traditional research approach | 4 | 13.3% | 15 | 50.0% | 11 | 36.7% | 2.23 | .04 |
| 2. Quality improvement/assurance activities | 2 | 6.7% | 18 | 60.0% | 10 | 33.3% | 2.27 | <.01 |
| 3. Determining the case mix (complexity) of patients/clients | 0 | 0.0% | 18 | 60.0% | 12 | 40.0% | 2.40 | .27 |
| 4. Comparing performance across therapists in terms of average patient/client outcomes | 1 | 3.3% | 17 | 56.7% | 12 | 40.0% | 2.37 | <.01 |
| 5. Comparing one clinic’s performance to that of other clinics | 2 | 6.7% | 16 | 53.3% | 12 | 40.0% | 2.33 | <.01 |
| 6. Comparing average outcomes of patients/clients with different conditions within a practice | 2 | 6.7% | 15 | 50.0% | 13 | 43.3% | 2.37 | <.01 |
| 7. Examining the average change in patients’/clients’ health status over their episodes of care to determine a practice’s effectiveness | 1 | 3.3% | 13 | 43.3% | 16 | 53.3% | 2.50 | <.01 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 8. Examining the average change in patients'/clients health status over their episodes of care to determine individual therapists' effectiveness | 0 | 0.0% | 14 | 45.6% | 16 | 53.3% | 2.53 | .71 |
| 9. Examining and documenting the status, progress, and/or outcomes of individual patients by individual therapists | 0 | 0.0% | 12 | 40.0% | 18 | 60.0% | 2.60 | .27 |
| 10. Communicating with other health care providers and referral sources | 1 | 3.3% | 9 | 30.0% | 20 | 66.7% | 2.63 | <.01 |
| Total "TS", Mean "MS", and proportional score PS ± SD | TS | 24.23 ± 3.09 | MS | 2.42 ± 0.309 | | PS. | 80.77% ± 10.31% | |

The gray highlighted sig values indicate significant difference between the categories of the matched variable

* The mean and the proportional scores ensure positive attitude of the sample subjects concerning the benefits of using SOMs for patients

## Table (4.5) Descriptive statistics of total, mean, and proportional Scores of sections (2-4) in the study questionnaire

| Scale | Total score /102 | | Mean* /3 | | Proportional/100 | |
|---|---|---|---|---|---|---|
| | Mean | SD | Mean | SD | Mean | SD |
| Benefits of SOM (out of 30) | 27.333 | 2.657 | 2.73 | 0.267 | 91.11 | 8.85 |
| Problems of SOM (out of 42) | 27.600 | 4.391 | 1.97 | 0.314 | 65.71 | 10.45 |
| Use of SOM (out of 30) | 24.233 | 3.092 | 2.42 | 0.309 | 80.77 | 10.30 |
| Overall (out of 102) | 79.167 | 6.913 | 2.32 | 0.203 | 77.61 | 6.77 |

The above table illustrates an overall analysis and summaries of total, mean, and proportional scores in the previous three tables, as well as the overall score of the three scales, which had a mean score of 79.167 ± 6.913 out of 102, that was converted to a mean of 2.32 ± 0.203 out of 3, which resulted in a proportional weight score of 77.61 ± 6.77 percent. In conclusion, it showed positive attitudes concerning the use and benefits of SOMs in rehabilitation.

### 4.1.5. The statistical results of answers related to Policies and procedures used in practice setting for collecting information from SOM

**Table (4.6) Frequency and ratio distribution of answers related to Policies or procedures used in your practice setting for collecting information from SOM**

| Question | Options | F | % | Chi-Square | df | Sig. |
|---|---|---|---|---|---|---|
| In my practice setting, completion of standardizes outcome measures is | Mandated/required for all patients. | 8 | 26.7 % | 11.600[a] | 5 | .04 |
| | Mandated only for patients/clients who have certain types of conditions (eg, low back pain) | 3 | 10.0 % | | | |
| | Routine for all patients/clients, but not mandated/required | 10 | 33.3 % | | | |
| | Routine, but not mandated, only for patients/clients who have certain types of conditions (eg, low back pain) | 3 | 10.0 % | | | |
| | Sporadic, depending on different factors such as time, patient's characteristics, etc | 5 | 16.7 % | | | |
| | Other | 1 | 3.3% | | | |
| In my practice setting, the types of standardizes outcome measures used include | Onlythosethatuseinformationderivedfrompatients'/clients'self-report. | 5 | 16.7 % | 12.200[b] | 2 | <.01 |
| | Only those that use information derived from observation of patients'/clients 'performance | 6 | 20.0 % | | | |
| | Acombinationofthosethatusepatient/clientself-reportandobservationoftheirperformance | 19 | 63.3 % | | | |
| In my practice setting, standardizes outcome measures are completed | Using paper, and therapists review the raw information from the paper version | 18 | 60.0 % | 21.467[c] | 3 | <.01 |

| | | | | | | |
|---|---|---|---|---|---|---|
| | Using paper, analyzed/ scored through scanner or computer data entry, and then summary scores are reviewed by therapists | 6 | 20.0 % | | | |
| | Using the computer (no paper), and summary scores are reviewed by therapists | 5 | 16.7 % | | | |
| | Other | 1 | 3.3% | | | |
| In my practice setting, when I use measures that require patients'/clients' self-reports | Using paper, and therapists review the raw information from the paper version | 14 | 46.7 % | 11.333[c] | 3 | .01 |
| | Using paper, analyzed/scored through scanner or computer data entry, and then summary scores are reviewed by therapists | 8 | 26.7 % | | | |
| | Using the computer(no paper),and summary scores are reviewed by therapists | 7 | 23.3 % | | | |
| | Other | 1 | 3.3% | | | |
| Each physical therapist in my practice setting | Uses the same health status questionnaires | 12 | 40.0 % | 1.200[d] | 1 | .27 |
| | Choosesthehealthstatusquestionnairesheorshewantstouse foreachpatient/client | 18 | 60.0 % | | | |
| I learned how to use standardized outcome measures | In my professional(entry-level) program | 13 | 43.3 % | 8.667[c] | 3 | .03 |
| | In my post professional education | 9 | 30.0 % | | | |
| | From continuing education workshops/conferences | 2 | 6.7% | | | |
| | From the other therapists or managers in my practice setting | 6 | 20.0 % | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| The criteria used for selecting the standardized outcome measures you use (multiple selection) | Can be completed quickly | 26 | 86.7% | 13.517[e] | 2 | <.01 |
| | Easy for patients/clients to understand | 29 | 96.7% | | | |
| | Easy for clinicians to understand/interpret meaning of scores and change in scores | 30 | 100.0% | | | |
| | Shown to be valid and reliable | 29 | 96.7% | | | |
| | Seem to be the most common ones used in physical therapist practice | 30 | 100.0% | | | |
| | Useful for a variety of purposes such as research, quality assurance, patient/client evaluation | 28 | 93.3% | | | |
| | Can be analyzed electronically (scanner, computer, etc.) | 30 | 100.0% | | | |
| | Most appropriate for the types of conditions seen in my practice setting | 30 | 100.0% | | | |
| | Other reason | 27 | 90.0% | | | |
| | Do not know | 11 | 36.7% | | | |

The gray highlights numbers indicate the highest ratios and the significant difference between the answers of the matched questions

## 4.1.6. Results related to reasons of not using the SOMs

## Table (4.7) Frequency and ratio distribution of questions related to Not using SOMs

| Questions | Options | F | % | Chi-Square | df | Asymp. Sig. |
|---|---|---|---|---|---|---|
| I do not use health status questionnaires with patients/clients because they (Multiple selection) | Are confusing to patients/clients | 5 | 16.7% | 13.333[d] | 1 | <.01 |
| | Are difficult for patients/clients to complete independently | 8 | 26.7% | 6.533[d] | 1 | .01 |
| | Require too high a reading level for many patients/clients | 7 | 23.3% | 8.533[d] | 1 | <.01 |
| | Are in English, a language in which many of my patients/clients are not fluent | 11 | 36.7% | 2.133[d] | 1 | .14 |
| | Are not sensitive to the cultural/ethnic concerns of many patients/clients | 2 | 6.7% | 22.533[d] | 1 | <.01 |
| | Make patients/clients anxious | 1 | 3.3% | 26.133[d] | 1 | <.01 |
| | Take too much time for patients/clients to complete | 10 | 33.3% | 3.333[d] | 1 | .06 |
| | Take too much of clinicians' time to analyze/calculate/score | 4 | 13.3% | 16.133[d] | 1 | <.01 |
| | Provide information that is too subjective to be useful | 1 | 3.3% | 26.133[d] | 1 | <.01 |
| | Require more effort than they are worth | 5 | 16.7% | 13.333[d] | 1 | <.01 |
| | Do not contain information that helps to direct the plan of care | 1 | 3.3% | 26.133[d] | 1 | <.01 |
| | Are difficult to interpret (eg, do not know what norms are, how score | 3 | 10.0% | 19.200[d] | 1 | <.01 |

| | | | | | | |
|---|---|---|---|---|---|---|
| | relates to severity, or what a clinically important change might be) | | | | | |
| | Do not contain the types of items or questions that are relevant for the types of patients/clients I see | 2 | 6.7% | 22.533[d] | 1 | <.01 |
| | Often do not get completed at discharge, so are not useful for determining patients'/clients' response to treatment | 3 | 10.0% | 19.200[d] | 1 | <.01 |
| | Require training that I do not have | 0 | 0.0% | 19.200[d] | 1 | <.01 |
| | Cost too much | 0 | 0.0% | | | |
| | Require a support structure that I do not have (eg, technology, staffing) | 3 | 10.0% | 19.200[d] | 1 | <.01 |
| | Are really only useful for research purposes | 3 | 10.0% | 19.200[d] | 1 | <.01 |
| | Are not relevant because my practice involves consultation, case management, or discharge planning only | 0 | 0.0% | | | |
| | Other reason | 5 | 16.7% | 13.333[d] | 1 | <.01 |
| I am planning to use SOM in the future | Yes | 17 | 56.7% | | | |
| | No | 1 | 3.3% | | | |
| | May be | 12 | 40.0% | | | |

The gray highlights numbers indicate the highest ratios and the significant difference between the answers of the matched questions

### 4.1.7. Prediction of using SOMs by demographic and professional factors of the study sample

**Table (4.8) Demographic factors as predictors for the use of SOMs**

| Predictor (reference) | Value | B | Wald | p-value | OR | 95% CI |
|---|---|---|---|---|---|---|
| Gender (male) | Female | 0.341 | 0.150 | 0.699 | 1.406 | 0.25 – 7.89 |
| Region (Jerusalem) | Jenin | - 0.693 | 0.175 | 0.676 | 0.500 | 0.01 – 12.89 |
| | Tulkarem | 20.510 | 0.000 | 1.000 | > 100 | --- |
| | Nablus | 0.405 | 0.079 | 0.779 | 1.500 | 0.08 – 25.39 |
| | Ramallah | - 0.288 | 0.052 | 0.819 | 0.750 | 0.06 – 8.83 |
| | Jericho | 20.510 | 0.000 | 1.000 | > 100 | --- |
| | Bethlehem | 20.510 | 0.000 | 0.999 | > 100 | --- |
| | Hebron | 1.386 | 1.025 | 0.311 | 4.000 | 0.27 – 58.56 |
| Experience (< 3 years) | 3-5 years | - 0.693 | 0.320 | 0.571 | 0.500 | 0.04 – 5.51 |
| | 6-10 years | - 0.693 | 0.320 | 0.571 | 0.500 | 0.04 – 5.51 |
| | 11-20 years | 1.204 | 0.821 | 0.365 | 3.333 | 0.24 – 45.10 |
| | >20 years | 20.104 | 0.000 | 1.000 | > 100 | --- |
| Highest earned degree (Professional) | Advanced master's | 0.234 | 0.037 | 0.847 | 1.263 | 0.11– 13.59 |
| Average sessions number | *** | - 0.092 | 0.484 | 0.487 | 0.912 | 0.70– 1.18 |

In the above table, the Binary logistic regression, was conducted to predict the dependent factor of using the SOM (after being converted to a dichotomous variable; yes or (no/maybe). The table shows that none of the independent variables is a significant predictor of SOM use.

### 4.1.8. Relationship between the main dimensions of study questionnaire

**Table (4.9) Correlations between treatment sessions and the main dimensions of study questionnaire**

| Factor | Benefits | | Problems | | Use | | Overall | |
|---|---|---|---|---|---|---|---|---|
| | Pearson | P | Pearson | P | Pearson | P | Pearson | P |
| Session number | 0.131 | 0.489 | 0.170 | 0.368 | 0.045 | 0.811 | 0.179 | 0.344 |
| Benefits | | | 0.044 | 0.816 | 0.279 | 0.111 | 0.545 | 0.002 |
| Problems | 0.044 | 0.816 | | | 0.220 | .0242 | 0.751 | < 0.001 |
| Use | 0.279 | 0.111 | 0.220 | .0242 | | | 0.701 | < 0.001 |
| Overall | 0.545 | | 0.751 | | 0.701 | | | |

The highlighted squares mean significant relationship between the related variables.

## 4-2 Results Discussion

As been illustrated in table 4.1, the majority of the respondents in this study were from the female category, with a percentage of 63.3%, compared to 36.7% from the male category, with no significant difference between both genders (p-value = 0.14), which gives the sample an advantage in the term of homogeneity according to the gender distribution. In terms of the geographical distribution of the respondents, the Hebron Governorate formed the vast majority of the sample (30%), followed by the Jerusalem Governorate (20%), and the Ramallah and Al-Bireh Governorate (16.7%), while the rest of the West Bank governorates formed the rest of the percentages, the least of which was 3.3% in the Tulkarm and Jericho governorates (p-value = 0.03), in which the significant difference was mostly related to the adoption of convenient sampling method.

The years of experience for the respondents had a significant difference (p-value = 0.03), as the category of 11 to 20 years got the highest percentage of 36.7% of the total sample. The bachelor's degree constituted the highest percentage among the respondents' degrees (83%), which was significantly different than the rest of the educational levels (p-value < 0.01). As for the certificate of specialization that pertains to the respondents, the orthopedic specialization was the highest value among them, as it constituted 43.3%, the manual therapy specialization by 33.3%, followed by the sports injury's specialization (10%), and the neurosciences and children specialization with 6.7%, while each of the senior specializations of geriatric and cardio-pulmonary possessed 0% of the sample size, which all is related to convenient sampling method.

The results of the analysis showed that the majority of the type of work facility for the respondents was in outpatients (83.3%, p-value < 0.01). As for the age group managed by the respondents, both categories of younger than 12 years old and 21 – 42 years old had similar percentages (6.7% each), while it was noted that the respondents who manage all ages constituted the largest percentage (86.7%). The conditions of the musculoskeletal system managed by the respondents accounted for 30%, while the mixed conditions accounted for 56.7%. This means that the majority of therapists are not specialized in treating specific conditions. The rate of sessions between 5-9 sessions was found among 56.7% of the therapists, which is the highest percentage of the respondents for the number of sessions during the day, which is proportional to the overall number of patients that regularly visit the targeted clinics.

Concerning the presented results in table 4.2, 23 out of 30 physical therapists reported using SOMs with their patients. The mean and the proportional scores ensure positive attitude among the study subjects concerning the benefits of using SOMs for their patients. Such results indicate positive professional awareness regarding the importance, the benefits and impact of using SOMs in rehabilitation, which was highlighted by the significant differences in the distribution of responses in most of the sentences (p-value < 0.05).

Concerning the interpretation of the presented results in table 4.3, the respondents' answers to the questions related to the possible problems in using the SOMs indicated a significant difference between the ordinal answers "ranks" in most questions of this section, with a total mean score of 1.97 out of 3 and an average proportional score of 65.71%, those scores reflect a

neutral attitude among the respondents toward the possible issues related to the use of SOMs in rehabilitation. The highest score of 76.7% (disagree) was in the question states that physical therapists had a problem in using SOMs because they are difficult for patients/clients to complete independently. Other said that using SOMs take too much time 46.7% (somewhat agree), while, 36.7% of the participants defiantly agree that using SOMs take too much time of clinicians to analyses\calculate\score.

The results of the statistical analyzes showed a positive attitude of the mean and the relative outcomes with regard to the use of SOMs with patients. In the other hand, the respondents' answers to the question related to examining and documenting the condition, progress and/or outcomes of individual patients by individual therapists, indicated a percentage of 60%, while their use of communication with other healthcare providers and referral sources indicated a response ratio of 66.7%. The use of SOMs in quality assurance/improvement activities and case mix determination (degree of complexity) for patients/clients indicated a percentage of 60%, although the use of SOMs in answering clinical questions through a traditional research approach had a percentage of 13.3%, which highlights the need for focus on the clinical research implications in the field of SOM among the Palestinian therapists ($p$-value $< 0.05$).

Table 4.8 was concerned with the investigation for the predictors of the use of SOM according to therapists' demographic factors, and showed that none of them is considered a significant predictor for the use of SOM. The main possible interpretation for the absence of such significance can be related to small sample size, which was reflected on heterogeneity in the distribution of participants within categories of each factor.

Therefore, it is recommended to conduct future studies with much larger sample size in Palestine, with the focus on trying to collect the participants with the highest possible level of homogeneity.

Compared with the Saudi study, female was not predictive of both studies. With regard to the years of experience, the years between 3-5 showed a positive expectation and the value of the OD was 9.2, and the years between 5-6 showed a positive effect with a value of 2.7 and the difference was significant.

As for our current study, the years of experience were between 11-20 years, a value of 3.3 showed a positive expectation of the benefit from the use of treatment and rehabilitation outcome measures. The difference was not significant between the groups.

The master's degree in both studies obtained a positive expectation in terms of the benefit of using treatment and rehabilitation outcome measures. The Saudi study showed 3.5(Al-Muqiren, Al-Eisa et al. 2017) while the current study of us in Palestine showed 1.2.

## 4.3 Study Limitations

The current study had several limitations:

- Many rehabilitation centers refused to participate in our study.
- Some physiotherapists refused to fill in the survey.
- Small sample size

# Chapter Five

# Conclusions and Recommendations

## 5.1 Conclusions

## 5.2 Recommendations

# Chapter Five

## 5.1 Conclusions

1. At the institutional level of the specialized rehabilitation centers in Palestine, there is a lack of confidence at the higher management, level concerning the current status, policies and rules related to the use of the SOMs in rehabilitation. Which lead to weak cooperation with the researcher, and even to refrain their therapists from filling the study questionnaire.
2. Up to the moment, there is no central decision in the Palestinian health care system to adopt and apply the SOMs in rehabilitation.
3. The majority of Palestinian physiotherapists working in the private sector of physiotherapy have a favorable, but not particularly profound, attitude toward the necessity, the advantages, and the usage of SOMs in rehabilitation.
4. There is a limited applied knowledge and a weak professional experience among the Palestinian physiotherapists concerning the professional use of SOMs in rehabilitation.
5. There is a very weak response rate among the Palestinian physiotherapists regarding their cooperation in filling the applied assessment tools of scientific research in general, and the questionnaires of nonparametric studies in particular.
6. The current status of using rehabilitation OMs in Palestine didn't offer the required assessment data to evaluate and to develop the effectiveness of the used physiotherapeutic services and interventions at the personal level of patient, physiotherapist, or at the institutional level of each organization in general.

## 5.2 Recommendations

1. There is a critical need for the decision makers in the Palestinian health care system, and the academic institutions / universities, to make the required and conclusive decision for adopting and applying the SOMs of rehabilitation, at the private as well as the public levels of rehabilitation sectors.
2. There is a critical need to hold specialized presentations to improve the professional and applied knowledge of using the ROMs among the Palestinian physiotherapist.
3. There is a critical need to hold professional workshops to improve the applied practical skills and the professional experience of using the ROMs among the Palestinian physiotherapist.
4. There is a critical need for professional cooperation between the national organizations of rehabilitation to build the national plan for the development of physiotherapy and rehabilitation services at the general level of Palestine.

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## Appendix I.

## The used questionnaire for the use of Standardized Outcome Measures in Physical Therapy Practice in Palestine

Please provide some information about your-self by checking the relevant box under each item?

1. your sex *"Mark only one"*

| | |
|---|---|
| | Female |
| | Male |

2. Region *"Mark only one"*

| | |
|---|---|
| | Jerusalem |
| | Jenin |
| | Tubas |
| | Tulkarm |
| | Nablus |
| | Qalqilya |
| | Salfit |
| | Ramallah and Al-Bireh |
| | Jericho |
| | Bethlehem |
| | Hebron |

*3.* The number of years you have practiced as a physical therapist *"Mark only one "*

| | |
|---|---|
| | <3 |
| | 3-5 |
| | 6-10 |
| | 11-20 |
| | >20 |

*4.* Your professional (entry-level) physical therapy degree *"Mark only one oval"*

| | |
|---|---|
| | Certificate |
| | Baccalaureate |
| | Master's |
| | Doctorate |

5. Your highest earned degree "*Mark only one"*

| | |
|---|---|
| | Professional |
| | Advanced master's |
| | Transitional DPT |
| | Doctorate |

6. Your specialty certification *"Mark only one"*

| | |
|---|---|
| | Cardiovascular-pulmonary |
| | Geriatric |
| | Neurology |
| | Orthopedic |
| | Pediatric |
| | Sports |
| | Manual therapy |
| | Hand therapy |

*7.* Your type of work facility "*Mark only one "*

| | |
|---|---|
| | Acute care |
| | Inpatient rehabilitation(including sub acute care) |
| | Extended care |
| | Outpatient |
| | Home health |
| | School system |

8. The age of the patient population you manage? *"Mark only one "*

| | |
|---|---|
| | <21 |
| | 21-40 |
| | 41-60 |
| | 61-75 |
| | >75 |
| | Treat all ages |

*9.* The types of conditions of the patient/client population you manage *"Mark only one "*

| | |
|---|---|
| | Musculoskeletal |
| | Neuromuscular |
| | Cardiovascular-pulmonary |
| | Woman's health |
| | Integumentary |
| | Mixed |

10. On average, how many treatment sessions do you complete in an 8-hour day? (If you work fewer or more than 8 hours a day, please extrapolate to 8 hours)

| |
|---|
| |

11. Did you use standardizes outcome measures with patient? "*Mark only one "*

| | |
|---|---|
| | Yes |
| | No |
| | Maybe |

Benefits of using standardizes outcome measures with patients/clients include?

12. Helping to direct the plan of care *"Mark only one "*

| | |
|---|---|
| | Definitely agree |
| | Agree somewhat |
| | Disagree |

*13.* Enhancing communication between therapist and patient/client *"Mark only one "*

| | |
|---|---|
| | Definitely agree |
| | Agree somewhat |
| | Disagree |

14. Enhancing communication with third-party payers, physicians, and other providers *"Mark only one "*

| | |
|---|---|
| | Definitely agree |
| | Agree somewhat |
| | Disagree |

15. Helping patients/clients feel that therapists are thorough in their examination *"Mark only one "*

| | |
|---|---|
| | Definitely agree |
| | Agree somewhat |
| | Disagree |

16. Increasing the efficiency of examinations *"Mark only one "*

| | |
|---|---|
| | Definitely agree |
| | Agree somewhat |
| | Disagree |

17. Helping to focus choice of interventions *"Mark only one "*

| | |
|---|---|
| | Definitely agree |
| | Agree somewhat |
| | Disagree |

18. Attaining better patient/client outcomes *"Mark only one "*

| | |
|---|---|
| | Definitely agree |
| | Agree somewhat |
| | Disagree |

19. Helping to motivate and encourage patients/clients *"Mark only one "*

| | |
|---|---|
| | Definitely agree |
| | Agree somewhat |
| | Disagree |

20. Decreasing the rates of denial from third-party payers *"Mark only one"*

| | |
|---|---|
| | Definitely agree |
| | Agree somewhat |
| | Disagree |

21. Enhanced marketing of my practice or services *"Mark only one"*

| | |
|---|---|
| | Definitely agree |
| | Agree somewhat |
| | Disagree |

22. Other benefit's

| |
|---|
| |

Problems in using health status questionnaires with patients/clients include, they:

23. Are confusing to patients/clients *"Mark only one"*

| | |
|---|---|
| | Definitely agree |
| | Agree somewhat |
| | Disagree |

*24.* Are difficult for patients/clients to complete independently *"Mark only one"*

| | |
|---|---|
| | Definitely agree |
| | Agree somewhat |
| | Disagree |

*25.* Require too high a reading level for many patients/clients *"Mark only one"*

| | |
|---|---|
| | Definitely agree |
| | Agree somewhat |
| | Disagree |

26. Are in English, a language in which many of my patients/clients are not fluent *"Mark only one"*

| | |
|---|---|
| | Definitely agree |
| | Agree somewhat |
| | Disagree |

*27.* Are not sensitive to the cultural/ethnic concerns of many patients/clients *"Mark one"*

| | |
|---|---|
| | Definitely agree |
| | Agree somewhat |
| | Disagree |

28. Make patients/clients anxious *"Mark only one"*

| | |
|---|---|
| | Definitely agree |
| | Agree somewhat |
| | Disagree |

29. Take too much time for patients/clients to complete *"Mark only one"*

| | |
|---|---|
| | Definitely agree |
| | Agree somewhat |
| | Disagree |

*30.* Take too much of clinicians' time to analyse/calculate/score *"Mark only one"*

| | |
|---|---|
| | Definitely agree |
| | Agree somewhat |
| | Disagree |

31. Provide information that is too subjective to be useful *"Mark only one "*

| | |
|---|---|
| | Definitely agree |
| | Agree somewhat |
| | Disagree |

32. Require more effort than they are worth *"Mark only one "*

| | |
|---|---|
| | Definitely agree |
| | Agree somewhat |

| | |
|---|---|
| | Disagree |

*33.* Do not contain information that helps to direct the plan of care *"Mark only one"*

| | |
|---|---|
| | Definitely agree |
| | Agree somewhat |
| | Disagree |

*34.* Are difficult to interpret (eg, do not know what norms are, how score relates to severity, or what a clinically important change might be) *"Mark only one"*

| | |
|---|---|
| | Definitely agree |
| | Agree somewhat |
| | Disagree |

35. Do not contain the types of items or questions that are relevant for the type of patients/clients I see *"Mark only one"*

| | |
|---|---|
| | Definitely agree |
| | Agree somewhat |
| | Disagree |

36. Often do not get completed at discharge, so cannot give information about patients'/clients' response to treatment *"Mark only one"*

| | |
|---|---|
| | Definitely agree |
| | Agree somewhat |
| | Disagree |

The following section contains items that ask how you use standardizes outcome measures with your patients/clients. If you practice in more than one setting, address the items considering the setting in which you do most of your practice.

**Please check only one box for each item. standardizes outcome measures are used for**

*37.* Answering clinical questions through a traditional research approach *"Mark only one "*

| | |
|---|---|
| | Yes, routinely |
| | Yes, sometimes |
| | No |

38. Quality improvement/assurance activities *"Mark only one"*

| | |
|---|---|
| | Yes, routinely |
| | Yes, sometimes |
| | No |

*39.* Determining the case mix (complexity) of patients/clients *"Mark only one"*

| | |
|---|---|
| | Yes, routinely |
| | Yes, sometimes |
| | No |

*40.* Comparing performance across therapists in terms of average patient/client outcomes *"Mark only one "*

| | |
|---|---|
| | Yes, routinely |
| | Yes, sometimes |

| | |
|---|---|
| | No |

*41.* Comparing one clinic's performance to that of other clinics *"Mark only one "*

| | |
|---|---|
| | Yes, routinely |
| | Yes, sometimes |
| | No |

42. Comparing average outcomes of patients/clients with different conditions within a practice *"Mark only one "*

| | |
|---|---|
| | Yes, routinely |
| | Yes, sometimes |
| | No |

*43.* Examining the average change in patients'/clients' health status over their episodes of care to determine a practice's effectiveness *"Mark only one"*

| | |
|---|---|
| | Yes, routinely |
| | Yes, sometimes |
| | No |

*44.* Examining the average change in patients'/clients' health status over their episodes of care to determine individual therapists' effectiveness *"Mark only one "*

| | |
|---|---|
| | Yes, routinely |
| | Yes, sometimes |

| | |
|---|---|
| | No |

*45.* Examining and documenting the status, progress, and/or outcomes of individual patients by individual therapists *"Mark only one "*

| | |
|---|---|
| | Yes, routinely |
| | Yes, sometimes |
| | No |

*46.* Communicating with other health care providers and referral sources *"Mark only one "*

| | |
|---|---|
| | Yes, routinely |
| | Yes, sometimes |
| | No |

The following section asks about policies or procedures used in your practice setting for collecting information from standardizes outcome measures. If you practice in more than one setting, address the items considering the setting in which you do most of your practice. Please check only one box for each item

47. In my practice setting, completion of standardizes outcome measures is? *"Mark only one"*

| | |
|---|---|
| | Mandated/required for all patients. |
| | Mandated only for patients/clients who have certain types of conditions (eg,low back pain) |
| | Routine for all patients/clients, but not mandated/required |

| | |
|---|---|
| | Routine, but not mandated, only for patients/clients who have certain types of conditions (eg, low back pain) |
| | Sporadic, depending on different factors such as time, patient's characteristics, etc |
| | Other |

48. In my practice setting, the types of standardizes outcome measures used include *"Mark only one "*

| | |
|---|---|
| | Onlythosethatuseinformationderivedfrompatients'/clients'self-report. |
| | Only those that use information derived from observation of patients'/clients 'performance |
| | Acombinationofthosethatusepatient/clientself-reportandobservationoftheirperformance |

*49.* In my practice setting, standardizes outcome measures are completed *"Mark only one "*

| | |
|---|---|
| | Using paper, and therapists review the raw information from the paper version |
| | Using paper, analyzed/scored through scanner or computer data entry, and then summary scores are reviewed by therapists |
| | Using the computer(no paper),and summary scores are reviewed by therapists |
| | Other |

50. In my practice setting, when I use measures that require patients'/clients' self-reports *"Mark only one"*

| | |
|---|---|
| | Using paper, and therapists review the raw information from the paper version |

| | |
|---|---|
| | Using paper ,analyzed/ scored through scanner or computer data entry, and then summary scores are reviewed by therapists |
| | Using the computer(no paper),and summary scores are reviewed by therapists |
| | Other |

51. Each physical therapist in my practice setting *"Mark only one oval"*

| | |
|---|---|
| | Uses the same health status questionnaires |
| | Choosesthehealthstatusquestionnairesheorshewantstouseforeachpatient/client |

52. I learned how to use standardised outcome measures *"Mark only one oval"*

| | |
|---|---|
| | In my professional(entry-level) program |
| | In my post professional education |
| | From continuing education workshops/conferences |
| | From the other therapists or managers in my practice setting |

53. Please indicate the criteria used for selecting the standardized outcome measures you use. Please check all that apply *"Check all that apply"*

| | |
|---|---|
| | Can be completed quickly |
| | Easy for patients/clients to understand |
| | Easy for clinicians to understand/interpret meaning of scores and change in scores |
| | Shown to be valid and reliable |

| | |
|---|---|
| | Seem to be the most common ones used in physical therapist practice |
| | Useful for a variety of purposes such as research, quality assurance, patient/client evaluation |
| | Can be analysed electronically (scanner, computer, etc) |
| | Most appropriate for the types of conditions seen in my practice setting |
| | Other reason |
| | Do not know |

54. Please list the standardized outcome measures that you use in your practice. Indicate which, if any, are your own "home-grown" questionnaires. Please spell out the name for each?

| | |
|---|---|
| | |
| | |
| | |

**If you DO NOT USE standardized outcome measures, please complete this section. As you complete it, think broadly about the tools that fall into the general category described with terms such as "health status," "quality of life," "disability functional status," or "outcome measures." This section of the survey contains items that ask for the reason that you do not use standardized outcome measures in your practice. Please check all that apply?

*55.* I do not use health status questionnaires with patients/clients because they *"Check all that apply"*

| |
|---|
| 1. Are confusing to patients/clients |

| |
|---|
| 2. Are difficult for patients/clients to complete independently |
| 3. Require too high a reading level for many patients/clients |
| 4. Are in English, a language in which many of my patients/clients are not fluent |
| 5. Are not sensitive to the cultural/ethnic concerns of many patients/clients |
| 6. Make patients/clients anxious |
| 7. Take too much time for patients/clients to complete |
| 8. Take too much of clinicians' time to analyze/calculate/score |
| 9. Provide information that is too subjective to be useful |
| 10. Require more effort than they are worth |
| 11. Do not contain information that helps to direct the plan of care |
| 12. Are difficult to interpret (eg, do not know what norms are, how score relates to severity, or what a clinically important change might be) |
| 13. Do not contain the types of items or questions that are relevant for the types of patients/clients I see |
| 14. Often do not get completed at discharge, so are not useful for determining patients'/clients' response to treatment |
| 15. Require training that I do not have |
| 16. Cost too much |
| 17. Require a support structure that I do not have (eg, technology, staffing) |
| 18. Are really only useful for research purposes |
| 19. Are not relevant because my practice involves consultation, case management, or discharge planning only |
| 20. Other reason |

| |
|---|
| |

*56.* I am planning to implement the use of standardizes outcome measures in the near future *"Mark only one"*

| | |
|---|---|
| | Yes |
| | No |
| | May be |

Appendix 2

# استبانة حول استخدام مقاييس مخرجات العلاج أو التأهيل في ممارسة العلاج الطبيعي في فلسطين

---

❖ يرجى تقديم بعض المعلومات الخاصة بك من خلال وضع علامة عند المربع الخاص بالإجابة أسفل كل عنصر؟

1. **جنسك *"ضع اي علامة على خيار واحد فقط"***

| | |
|---|---|
| **أنثى** | |
| **ذكر** | |

2. المنطقة *"ضع اي علامة على خيار واحد فقط"*

| | |
|---|---|
| القدس | |
| جنين | |
| طوباس | |
| طولكرم | |
| نابلس | |
| قلقيلية | |
| سلفيت | |
| رام الله والبيرة | |
| أريحا | |
| بيت لحم | |
| الخليل | |

*3.* عدد سنوات عملك كمختص علاج طبيعي *"ضع اي علامة على خيار واحد فقط"*

| | |
|---|---|
| أقل من 3 | |
| 5-3 | |
| 10-6 | |
| 20-11 | |
| أكثر من 20 | |

*4.* درجتك المهنية عند التحاقك بالعمل في العلاج الطبيعي*"ضع اي علامة على خيار واحد فقط"*

| | |
|---|---|
| شهادة | |
| بكالوريوس | |
| ماجستير | |
| دكتوراه | |

5. أعلى درجة علمية حصلت عليها *" ضع اي علامة على خيار واحد فقط"*

| | |
|---|---|
| مختص | |
| ماجستير متقدم | |
| تجسير للدكتور المهني في العلاج الطبيعي | |
| دكتوراه | |

6. تخصصك الدقيق في العلاج الطبيعي*"ضع اي علامة على جواب واحد فقط"*

| | |
|---|---|
| القلب والأوعية الدموية الرئوية | |
| الشيخوخة | |
| علم الأعصاب | |
| تقويم العظام | |
| أخصائي أطفال | |
| رياضات | |
| علاج يدوي | |
| علاج اليدين | |

7. نوع منشأة العمل الخاص بك *"ضع اي علامة على خيار واحد فقط"*

| | |
|---|---|
| رعاية مركزة | |
| إعادة تأهيل المرضى الداخليين (بما في ذلك الرعاية تحت الحرجة) | |
| الرعاية الموسعة | |
| العيادات الخارجية | |
| صحة منزلية | |
| نظام مدرسة | |

8. عمر فئة المرضى الذين تعالجهم؟ *"ضع اي علامة على جواب واحد فقط"*

| | |
|---|---|
| أقل من 21 | |
| 40-21 | |
| 60-41 | |
| 75-61 | |
| أكبر من 75 | |
| معالج لجميع الأعمار | |

*9.* نوع حالات المرضى الذين تعالجهم*"ضع اي علامة علىجواب واحد فقط"*

| | |
|---|---|
| الجهاز العضلي الهيكلي | |
| الجهاز العصبي العضلي | |
| القلب والأوعية الدموية الرئوية | |
| صحة المرأة | |
| الجهاز اللحافي | |
| مختلط | |

10 .كمعدل وسطي، ما هو عدد جلسات العلاج التي تكملها في 8 ساعات في اليوم؟ (إذا كنت تعمل أقل أو أكثر من 8 ساعات في اليوم، فيرجى استنتاج عدد الجلسات التي تكملها خلال 8 ساعات عمل)

| |
|---|
| |

10. هل سبق لك ان استخدمت مقاييس مخرجات العلاج أو التأهيل مع المرضى اللذين تعالجهم؟

*"ضع اي علامة على جواب واحد فقط"*

| | |
|---|---|
| نعم | |
| لا | |
| ربما | |

❖ **تتضمن فوائد استخدام مقاييس مخرجات العلاج او التأهيل مع المرضى ما يلي؟**

22. المساعدة في توجيه خطة العلاج *"ضع اي علامة على جواب واحد فقط"*

| | |
|---|---|
| أوافق بالتأكيد | |
| أوافق إلى حد ما | |
| أعارض | |

*23.* تعزيز التواصل بين المعالج والمريض *"ضع اي علامة على جواب واحد فقط"*

| | |
|---|---|
| أوافق بالتأكيد | |
| أوافق إلى حد ما | |
| أعارض | |

24. تعزيز التواصل مع الجهات التي تغطي نفقات العلاج والأطباء وغيرهم *"ضع اي علامة على جواب واحد فقط"*

| | |
|---|---|
| أوافق بالتأكيد | |
| أوافق إلى حد ما | |
| أعارض | |

25. مساعدة المرضى على الشعور بأن المعالجين دقيقون في فحصهم *"ضع اي علامة على جواب واحد فقط"*

| | |
|---|---|
| أوافق بالتأكيد | |
| أوافق إلى حد ما | |
| أعارض | |

26. زيادة كفاءة الفحوصات *"ضع اي علامة على جواب واحد فقط"*

| | |
|---|---|
| أوافق بالتأكيد | |
| أوافق إلى حد ما | |
| أعارض | |

27. المساعدة في التركيز على اختيار التدخلات العلاجية المناسبة *"ضع اي علامة على جواب واحد فقط"*

| | |
|---|---|
| أوافق بالتأكيد | |
| أوافق إلى حد ما | |
| أعارض | |

28. تحقيق نتائج أفضل للمريض *"ضع اي علامة على جواب واحد فقط"*

| | |
|---|---|
| أوافق بالتأكيد | |
| أوافق إلى حد ما | |
| أعارض | |

29. المساعدة في تحفيز المرضى وتشجيعهم *"ضع/ي علامة على جواب واحد فقط"*

| | |
|---|---|
| أوافق بالتأكيد | |
| أوافق إلى حد ما | |
| أعارض | |

30. خفض معدلات الرفض من الجهات الخارجية الدافعة *"ضع/ي علامة على جواب واحد فقط"*

| | |
|---|---|
| أوافق بالتأكيد | |
| أوافق إلى حد ما | |
| أعارض | |

31. تحسين تسويق خدماتي العلاجية *"ضع/ي علامة على جواب واحد فقط"*

| | |
|---|---|
| أوافق بالتأكيد | |
| أوافق إلى حد ما | |
| أعارض | |

32. فوائد أخرى

| |
|---|
| |

***من معيقات استخدام استيانات الحالة الصحية مع المرضى ما يلي:**

33. مربكة للمرضى *"ضع اي علامة على جواب واحد فقط"*

| | |
|---|---|
| أوافق بالتأكيد | |
| أوافق إلى حد ما | |
| أعارض | |

*34.* يصعب على المرضى إكمالها بشكل مستقل *"ضع اي علامة على جواب واحد فقط"*

| | |
|---|---|
| أوافق بالتأكيد | |
| أوافق إلى حد ما | |
| أعارض | |

*35.* تتطلب مستوى اعلى من التعليمات لدى المرضى *"ضع اي علامة على جواب واحد فقط"*

| | |
|---|---|
| أوافق بالتأكيد | |
| أوافق إلى حد ما | |
| أعارض | |

36. اللغة الإنجليزية، وهي لغة لا يجيدها العديد من مرضاي *"ضع اي علامة على جواب واحد فقط"*

| | |
|---|---|
| أوافق بالتأكيد | |
| أوافق إلى حد ما | |
| أعارض | |

*37.* لا تراعي الحساسية المرتبطة بالجوانب الثقافية والأخلاقية للعديد من المرضى*"ضع اي علامة على جواب واحد*

| | |
|---|---|
| أوافق بالتأكيد | |
| أوافق إلى حد ما | |
| أعارض | |

38. تجعل المرضى أكثر قلقا *"ضع اي علامة على جواب واحد فقط"*

| | |
|---|---|
| أوافق بالتأكيد | |
| أوافق إلى حد ما | |
| أعارض | |

39. يستغرق المرضى وقتًا طويلاً لإكمالها *"ضع اي علامة على جواب واحد فقط"*

| | |
|---|---|
| أوافق بالتأكيد | |
| أوافق إلى حد ما | |
| أعارض | |

*40.* تتطلب من المختصين وقتًا طويلاً للتحليل وحساب وتسجيل درجاتها *"ضع اي علامة على جواب واحد فقط"*

| | |
|---|---|
| أوافق بالتأكيد | |
| أوافق إلى حد ما | |
| أعارض | |

41. تتطلب معلومات ذاتية للغاية بحيث لا تكون مفيدة *"ضع اي علامة على جواب واحد فقط"*

| | |
|---|---|
| أوافق بالتأكيد | |
| أوافق إلى حد ما | |
| أعارض | |

42. تتطلب مجهودًا أكثر مما تستحق *"ضع اي علامة على جواب واحد فقط"*

| | |
|---|---|
| أوافق بالتأكيد | |
| أوافق إلى حد ما | |
| أعارض | |

*43.* لا تحتوي على معلومات تساعد في توجيه خطة العلاج*"ضع اي علامة على جواب واحد فقط"*

| | |
|---|---|
| أوافق بالتأكيد | |
| أوافق إلى حد ما | |
| أعارض | |

*44.* يصعب تفسيرها (على سبيل المثال، لا تعرف ما هي المعايير، أو كيف ترتبط درجة المخرج العلاجي المستخدم بشدة الحالة المرضية، وما هو التدخل السريري المطلوب)*"ضع اي علامة على جواب واحد فقط"*

| | |
|---|---|
| أوافق بالتأكيد | |
| أوافق إلى حد ما | |
| أعارض | |

45. لا تحتوي على المفردات أو الأسئلة ذات الصلة بنوع المرضى الذين أتعامل معهم *"ضع اي علامة على جواب واحد فقط"*

| | |
|---|---|
| أوافق بالتأكيد | |
| أوافق إلى حد ما | |
| أعارض | |

46. غالبًا لا تكتمل عند خروج المرضى، لذلك لا يمكن إعطاء معلومات حول استجابة المرضى للعلاج *"ضع اي علامة على جواب واحد فقط"*

| | |
|---|---|
| أوافق بالتأكيد | |
| أوافق إلى حد ما | |
| أعارض | |

❖ **يحتوي القسم التالي على أسئلة حول كيفية استخدامك لمقاييس النتائج مع مرضاك. إذا كنت تتدرب في أكثر من مكان، فقم بالإجابة على الأسئلة مع مراعاة المكان الذي تمارس فيه معظم عملك. يرجى تحديد مربع واحد فقط لكل سؤال. تستخدم مقاييس النتائج الموحدة في:**

*47.* الإجابة على الأسئلة السريرية من خلال منهج بحث تقليدي *"ضع اي علامة على جواب واحد فقط"*

| | |
|---|---|
| نعم، بشكل روتيني | |
| نعم أحياناً | |
| لا | |

48. أنشطة لتحسين ضمان الجودة *"ضع اي علامة على جواب واحد فقط"*

| | |
|---|---|
| نعم، بشكل روتيني | |
| نعم أحياناً | |
| لا | |

*49.* تحديد مدى إمكانية توحيد التعامل مع الحالات المعقدة من للمرضى *"ضع اي علامة على جواب واحد فقط"*

| | |
|---|---|
| نعم، بشكل روتيني | |
| نعم أحياناً | |
| لا | |

*50.* مقارنة الأداء بين المعالجين من حيث متوسط تحسن نتائج أداء المرضى بين المعالجين*"ضع اي علامة على جواب واحد فقط"*

| | |
|---|---|
| نعم، بشكل روتيني | |
| نعم أحياناً | |
| لا | |

*51.* مقارنة مستوى الخدمات السريرية بين العيادات المختلفة*"ضع اي علامة على جواب واحد فقط"*

| | |
|---|---|
| نعم، بشكل روتيني | |
| نعم أحياناً | |
| لا | |

**52.. مقارنة متوسط تحسن نتائج المرضى الذين يعانون من حالات مختلفة في حال استخدامهم ذات المخرج العلاجي او التأهيلي *"ضع اي علامة على جواب واحد فقط"***

| | |
|---|---|
| نعم، بشكل روتيني | |
| نعم أحياناً | |
| لا | |

***53.* فحص متوسط التغيير في الحالة الصحية للمرضى خلال فترات الرعاية المتتالية لتحديد مدى فعالية الممارسة العلاجية المستخدمة*"ضع اي علامة على جواب واحد فقط"***

| | |
|---|---|
| نعم، بشكل روتيني | |
| نعم أحياناً | |
| لا | |

*54.* **فحص متوسط التغيير في الحالة الصحية للمرضى خلال فترات الرعاية المتتالية لغرض المفاضلة بين التدخلات العلاجية المستخدمة من قبل المعالجين *"ضع ايعلامة على جواب واحد فقط"***

| | |
|---|---|
| نعم، بشكل روتيني | |
| نعم أحياناً | |
| لا | |

***55.* فحص وتوثيق الحالة وتقدمها واو المخرج العلاجي لتحسن مريض ما او لكفاءة عمل معالج ما *"ضع اي علامة على جواب واحد فقط"***

| | |
|---|---|
| نعم، بشكل روتيني | |
| نعم أحياناً | |
| لا | |

***56.*. تسهيل التواصل مع مقدمي الخدمات الصحية من مختلف مصادر تحويل المرضى *"ضع اي علامة على جواب واحد"***

| | |
|---|---|
| نعم، بشكل روتيني | |
| نعم أحياناً | |
| لا | |

- **يسأل القسم التالي عن السياسات أو الإجراءات المستخدمة في مكان العمل الخاص بك لجمع المعلومات من مقاييس مخرجات العلاج او التأهيل. إذا كنت تتدرب في أكثر من مكان، فقم بالإجابة عن الأسئلة مع مراعاة المكان الذي تمارس فيه معظم عملك. يرجى تحديد مربع واحد فقط لكل إجابة:**

**57.في مكان عملي، يعتبر استكمال مقاييس مخرجات العلاج والتأهيل؟** ***"ضع اي علامة على جواب واحد فقط"***

| | |
|---|---|
| إلزامي/ مطلوب لجميع المرضى. | |
| مخصص فقط للمرضى الذين يعانون من أنواع معينة من الحالات (على سبيل المثال، آلام أسفل الظهر) | |
| روتيني لجميع المرضى، ولكن ليس إلزاميًا / مطلوبًا | |
| روتيني، ولكن ليس إلزاميًا، فقط للمرضى الذين يعانون من أنواع معينة من الحالات (على سبيل المثال، آلام أسفل الظهر) | |
| متقطع حسب عوامل مختلفة مثل الوقت وخصائص المريض وما إلى ذلك | |
| أخرى | |

58.**في مكان عملي، تشمل أنواع مقاييس مخرجات العلاج والتأهيل***"ضع اي علامة على جواب واحد فقط"*

| | |
|---|---|
| أولئك الذين يستخدمون المعلومات المستمدة من التقرير الذاتي للمرضى فقط. | |
| أولئك الذين يستخدمون المعلومات المستمدة من مراقبة أداء المرضى فقط | |
| مزيج من أولئك الذين يستخدمون التقرير الذاتي للمريض ومراقبة أدائهم | |

59. في إطار عملي، يتم استكمال مقاييس مخرجات العلاج والتأهيل *"ضع اي علامة على جواب واحد فقط"*

| | |
|---|---|
| باستخدام الورق، يقوم المعالجون بمراجعة المعلومات الأولية من النسخة الورقية | |
| باستخدام الورق، يتم تحليله / تسجيله من خلال الماسح الضوئي أو إدخال بيانات الكمبيوتر، ثم يتم مراجعة ملخص الدرجات من قبل المعالجين | |
| باستخدام الكمبيوتر (بدون ورقة)، يتم مراجعة ملخص الدرجات من قبل المعالجين | |
| أخرى | |

60. في مكان عملي، عندما يتطلب الامر استخدام ملفات المرضى *"ضع اي علامة على جواب واحد فقط"*

| | |
|---|---|
| باستخدام الورق، يقوم المعالجون بمراجعة المعلومات الأولية من النسخة الورقية | |
| باستخدام الورق، يتم تحليله / تسجيله من خلال الماسح الضوئي أو إدخال بيانات الكمبيوتر، ثم يتم مراجعة ملخص الدرجات من قبل المعالجين | |
| باستخدام الكمبيوتر (بدون ورقة)، يتم مراجعة ملخص الدرجات من قبل المعالجين | |
| أخرى | |

61. كل معالج فيزيائي في مكان عملي *"ضع اي علامة على جواب واحد فقط"*

| | |
|---|---|
| يستخدم نفس الاستبيانات الصحية ذات العلاقة بمقاييس مخرجات العلاج او التأهيل المقدم للمرضى | |
| يختار استبيانات الحالة الصحية التي يريد استخدامها لكل مريض | |

62. تعلمت كيفية استخدام مقاييس مخرجات العلاج او التأهيل *"ضع اي علامة على جواب واحد فقط"*

| | |
|---|---|
| في برنامجي المهني (مستوى الدخول) | |
| ما بعد التعليم المهني | |
| من ورش عمل / مؤتمرات التعليم المستمر | |
| من المعالجين أو المديرين الآخرين في مكان عملي | |

63 . يرجى الإشارة إلى المعايير المستخدمة لاختيار او تفضيل مقاييس مخرجات العلاج او التأهيل المطبقة.
يرجى تحديد كل ما ينطبق *"حدد اي كل ما ينطبق"*

| | |
|---|---|
| يمكن إكمالها بسرعة | |
| يسهل على المرضى فهمها | |
| من السهل على الأطباء فهم / تفسير الدرجات وتغيير الدرجات | |
| أن تكون صالحة وموثوقة | |
| يبدو أنها الأكثر شيوعًا في ممارسة العلاج الطبيعي | |
| مفيدة لمجموعة متنوعة من الأغراض مثل البحث وضمان الجودة وتقييم المريض | |
| يمكن تحليلها إلكترونيا (ماسح ضوئي، كمبيوتر، الخ) | |
| تعتبر الأكثر ملاءمة لأنواع الظروف التي تظهر في مكان عملي | |
| أسباب أخرى | |
| لا أعلم | |

64. يرجى ذكر مقاييس مخرجات العلاج او التأهيل التي تستخدمها في عملك. حدد الاستبيانات "المحلية" الخاصة

| | |
|---|---|
| | |

** إذا كنت لا تستخدم مقاييس مخرجات العلاج او التأهيل، يرجى إكمال هذا القسم. عند إكمالها، فكر على نطاق واسع في الأدوات التي تندرج في الفئة العامة الموصوفة بمصطلحات مثل "الحالة الصحية" أو "جودة الحياة" أو "الحالة الوظيفية للإعاقة" أو "مقاييس مخرجات العلاج او التأهيل".

65. **لا أستخدم استبيانات مخرجات العلاج او التأهيل مع المرضى لأنها "اختر كل ما ينطبق عليك بك، إن وجدت. الرجاء تهجئة اسم لكل منهما؟**

| | |
|---|---|
| مربكة للمرضى حيث يصعب على المرضى إكمالها بشكل مستقل | |
| تتطلب مستوى قراءة مرتفعًا جدًا للعديد من المرضى | |
| اللغة الإنجليزية، وهي لغة لا يجيدها العديد من مرضاي | |
| لا تعتبر حساسة تجاه الاهتمامات الثقافية / العرقية للعديد من المرضى | |
| تساهم في جعل المرضى في حالة قلق | |
| يستغرق المرضى الكثير من الوقت لإكمالها | |
| تأخذ الكثير من وقت المختصين في تحليل وحساب وتوثيق نتيجتها | |
| تقدم معلومات ذاتية للغاية بحيث لا تكون مفيدة | |
| تتطلب جهدا أكثر مما تستحق | |
| لا تحتوي على معلومات تساعد في توجيه خطة الرعاية | |
| يصعب تفسيرها (على سبيل المثال، لا تعرف ما هي المعايير، أو كيف ترتبط جرحة المخرج العلاجي او التأهيلي مع شدة الحالة المرضية، أو ما هي اهمية التدخل السريري المطلوب) | |
| لا تحتوي على أنواع المفردات أو الأسئلة ذات الصلة بأنواع المرضى الذين أراهم | |
| في كثير من الأحيان لا يتم إكمالها بعد خروج المريض، لذلك فهي ليست مفيدة لتحديد استجابة المرضى للعلاج | |
| تتطلب التدريب وأنا لا أملكه | |
| مكلفة للغاية | |
| تتطلب هيكل دعم وهو غير متوفر لدي (على سبيل المثال، التكنولوجيا والموظفين) | |
| تعتبر مفيدة لأغراض البحث فقط | |
| ليست ذات صلة لأن ممارستي تتضمن التشاور أو إدارة الحالة أو التخطيط للتسريح فقط | |

| | |
|---|---|
| أسباب أخرى | |

66. أخطط لتنفيذ استخدام مقاييس مخرجات العلاج او التأهيل في المستقبل القريب *"ضع اي علامة على جواب واحد فقط"*

| | |
|---|---|
| نعم | |
| لا | |
| ربما | |

# Appendix III. Letter of

# Ethical approval

Al Quds University
Faculty of Health Professions
Jerusalem –Abu Dis

جامعة القدس
كلية المهن الصحية
القدس – أبو ديس

**Research Ethics Subcommittee of Faculty of Health Professions**
**Letter of approval**

**Sep. 1st, 2022**
**Ref. No.: RESC/2022-17**

Dear Applicants, **(Dr. Abdulhamid M. Zeer, Ms. Raia Marjan)**
Program: **MSc Physiotherapy and Rehabilitation Department**

The Research Ethics subcommittee of the Faculty of Health Professions has recently reviewed your proposal entitled **(The use of rehabilitation outcome measures in Palestine: A descriptive study)** submitted by **(Dr. Abdulhamid M. Zeer)**.
Your proposal is deemed to meet the requirements of research ethics at Al-Quds University, but further assessment is required by the Central Research Ethics Committee of Al-Quds University. We wish you all best for the conduct of the project.

**Hussein AL.Masri, PhD**
**Associate Professor of Medical Imaging**
**Research Ethics Subcommittee Chair**
**Faculty of Health Professions**

Hussein AlMasri

CC: File
CC: Committee members

Tel. Fax: 02 2791243 Email: dean@hpro.alquds.edu تلفاكس: 02 2791243